MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
QUALITY ASSURANCE DIVISION
NURSE AIDE REGISTRY
PO BOX 202953, HELENA MT 59620-2953
CNA@MT.GOV
PHONE: 406-444-4980
FAX: 406-444-3456

NURSE AIDE AND HOME HEALTH REGISTRY RENEWAL APPLICATION

PLEASE NOTE THAT AS OF JANUARY 31, 2012 THE REGISTRY WILL NO LONGER BE SENDING CARDS TO CNAS/HHAS. VERIFICATIONS CAN BE PRINTED THROUGH OUR WEBSITE: cna.mt.gov

SECTION I: APPLICANT'S PERSONAL INFORMATION

Name:____
Last First Middle Initial Maiden (or Previous)

Mailing Address: ____

____
City State Zip Code

Home Phone: ______________ Cell Phone: ______________ Work Phone: _____________

Date of Birth: ____________________________ SSN (Last 4 Digits): ______________

Type: CNA ________ CNA/HHA ________ State ID#: _________________________

SECTION II: EMPLOYMENT INFORMATION

Your employment information determines your certification status. Unless provided accurately, you risk not being recertified. List all employers for whom you worked as a CNA in the past 2 years.

Employer Name	Employer Phone Number	Dates Worked

____ __________________________
APPLICANT'S SIGNATURE DATE

There is no grace period to renew your certification. No renewal fee required.
If you have questions or need assistance in completing this form, please contact the Montana Nurse Aide Registry.

Name of Applicant: ____________________________________

SECTION III: EMPLOYER INFORMATION

Employer's Name: ____

Employer's Address: ____

____
City State Zip Code

Type of Facility (Please check one of the following):

_____ Licensed Health Care Facility or Agency
_____ Physician's Office or Clinic
_____ Private Duty
_____ Other (Please Indicate) ____

SECTION IV: VERIFICATION OF EMPLOYMENT

Is employee currently working at your facility? Yes _____ No _____

If No is marked, date last worked at your facility: _______________________________

The employee listed on the reverse side of the form has worked in your facility for which they have received a wage.

____ _________________________
Authorized Signature Date
(Administrator/DON/Staff Development Coordinator)

FOR HOME HEALTH ONLY

Please enter the number of hours of in-service education you have provided to this applicant for each of the past two years.

_______ __________
1st Year 2nd Year

You must present this form to your current or former employer for whom you last worked providing nursing related services for verification of employment. Your renewal will not be processed unless your employment is verified.